

## ESRD DEATH NOTIFICATION

### END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0448. The time required to complete this information collection is estimated to average 17 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

1. Patient's Last Name		First	MI	2. Health Insurance Claim Number	
3. Patient's Sex a. <input type="checkbox"/> Male    b. <input type="checkbox"/> Female		4. Date of Birth Month: <input type="text"/> <input type="text"/> Day: <input type="text"/> <input type="text"/> Year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		5. Social Security Number <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
6. Patient's State of Residence		7. Place of Death a. <input type="checkbox"/> Hospital    c. <input type="checkbox"/> Home    e. <input type="checkbox"/> Other b. <input type="checkbox"/> Dialysis Unit    d. <input type="checkbox"/> Nursing Home		8. Date of Death Month: <input type="text"/> <input type="text"/> Day: <input type="text"/> <input type="text"/> Year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
9. Modality at Time of Death a. <input type="checkbox"/> Incenter Hemodialysis    b. <input type="checkbox"/> Home Hemodialysis    c. <input type="checkbox"/> IPD    d. <input type="checkbox"/> CAPD    e. <input type="checkbox"/> CCPD    f. <input type="checkbox"/> Transplant					
10. Provider Name and Address (Street)				11. Provider Number	
Provider Address (City/State)					
12. Causes of Death (enter codes from list on back of form) a. Primary Cause <input type="text"/> <input type="text"/> <input type="text"/> b. Were there secondary causes? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>					
13. Renal replacement therapy discontinued prior to death: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check one of the following: a. <input type="checkbox"/> Following HD and/or PD access failure b. <input type="checkbox"/> Following transplant failure c. <input type="checkbox"/> Following chronic failure to thrive d. <input type="checkbox"/> Following acute medical complication e. <input type="checkbox"/> Other f. Date of last dialysis treatment    Month: <input type="text"/> <input type="text"/> Day: <input type="text"/> <input type="text"/> Year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				14. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. If deceased received a transplant: a. Date of most recent transplant    Month: <input type="text"/> <input type="text"/> Day: <input type="text"/> <input type="text"/> Year: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> b. Type of transplant received <input type="checkbox"/> Living Related <input type="checkbox"/> Living Unrelated <input type="checkbox"/> Cadaveric c. Was kidney functioning (patient not on dialysis at time of death)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown d. Did transplant patient resume chronic maintenance dialysis prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				16. Was patient receiving Hospice care prior to death?  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Unknown	
17. Name of Physician		Signature of Person Completing This Form			Date

This report is required by law (42, U.S.C. 426; 20 CFR 405, Section 2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 U.S.C. 5520; 45 CFR Part 5a).

## **ESRD DEATH NOTIFICATION FORM**

### **LIST OF CAUSES**

#### **CARDIAC**

- 23 Myocardial infarction, acute
- 25 Pericarditis, incl. Cardiac tamponade
- 26 Atherosclerotic heart disease
- 27 Cardiomyopathy
- 28 Cardiac arrhythmia
- 29 Cardiac arrest, cause unknown
- 30 Valvular heart disease
- 31 Pulmonary edema due to exogenous fluid
- 32 Congestive Heart Failure

#### **VASCULAR**

- 35 Pulmonary embolus
- 36 Cerebrovascular accident including intracranial hemorrhage
- 37 Ischemic brain damage/Anoxic encephalopathy
- 38 Hemorrhage from transplant site
- 39 Hemorrhage from vascular access
- 40 Hemorrhage from dialysis circuit
- 41 Hemorrhage from ruptured vascular aneurysm
- 42 Hemorrhage from surgery (not 38, 39, or 41)
- 43 Other hemorrhage (not 38-42, 72)
- 44 Mesenteric infarction/ischemic bowel

#### **INFECTION**

- 33 Septicemia due to internal vascular access
- 34 Septicemia due to vascular access catheter
- 45 Peritoneal access infectious complication, bacterial
- 46 Peritoneal access infectious complication, fungal
- 47 Peritonitis (complication of peritoneal dialysis)
- 48 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
- 51 Septicemia due to peripheral vascular disease, gangrene
- 52 Septicimia, other
- 61 Cardiac infection (endocarditis)
- 62 Pulmonary infection (pneumonia, influenza)
- 63 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular, disease, gallbladder)
- 70 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

#### **LIVER DISEASE**

- 64 Hepatitis B
- 71 Hepatitis C
- 65 Other viral hepatitis
- 66 Liver-drug toxicity
- 67 Cirrhosis
- 68 Polycystic liver disease
- 69 Liver failure, cause unknown or other

#### **GASTRO-INTESTINAL**

- 72 Gastro-intestinal hemorrhage
- 73 Pancreatitis
- 75 Perforation of peptic ulcer
- 76 Perforation of bowel (not 75)

#### **METABOLIC**

- 24 Hyperkalemia
- 77 Hypokalemia
- 78 Hypernatremia
- 79 Hyponatremia
- 100 Hypoglycemia
- 101 Hyperglycemia
- 102 Diabetic coma
- 95 Acidosis

#### **ENDOCRINE**

- 96 Adrenal insufficiency
- 97 Hypothyroidism
- 103 Hyperthyroidism

#### **OTHER**

- 80 Bone marrow depression
- 81 Cachexia/failure to thrive
- 82 Malignant disease, patient ever on Immunosuppressive therapy
- 83 Malignant disease (not 82)
- 84 Dementia, incl. dialysis dementia, Alzheimer's
- 85 Seizures
- 87 Chronic obstructive lung disease (COPD)
- 88 Complications of surgery
- 89 Air embolism
- 104 Withdrawal from dialysis/uremia
- 90 Accident related to treatment
- 91 Accident unrelated to treatment
- 92 Suicide
- 93 Drug overdose (street drugs)
- 94 Drug overdose (not 92 or 93)
- 98 Other identified cause of death, please specify:

---

99. Unknown